the care pathway to ensure rapid assessment and treatment for TIA patients would avoid 128 future stroke events over three years. As a result, the costs associated with the reconfiguration of the TIA patient care pathway would be partially offset by savings in acute stroke management costs. CONCLUSIONS: Our model suggests that implementing a revised TIA care pathway in Hungary would result in a reduction of TIA-related recurrent strokes, leading to reduced costs associated with the acute management of stroke. This would partially offset the costs of establishing rapid assessment and treatment clinics for patients experiencing TIA.

PCV53
FINANCIAL IMPACT OF A NOVEL PRECLEMSA DIAGNOSTIC TEST VS. STANDARD CARE: A DECISION-ANALYTIC MODELING ANALYSIS FROM A UK HEALTH CARE PAYER PERSPECTIVE
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OBJECTIVES: Precordiaplasms, a leading cause of maternal and perinatal morbidity and mortality, is only detected after the onset of clinical symptoms. Earlier diagnosis may be possible with a new serum test using soluble fms-like tyrosine kinase-1 (sFlt-1) and placental growth factor (PIGF) biomarkers. Clinical and economic benefits may result from appropriate detection and management of subclinical cases, and from averting costs associated with incorrect diagnoses. We evaluated the financial impact of the novel test versus standard care from a UK health care payer perspective.

METHODS: We developed a decision-analytic model of the clinical and economic impact of implementing an improved sensitivity and specificity of the new test over current diagnostic practice. Acute management and follow-up costs were associated with true positive, true negative, false positive, and false negative diagnoses. The base-case analysis assumed that, of all pregnant women, 15% present with risk factors which would warrant a test. The CHF 52 (€-equivalent) test was assumed to be administered after 20 weeks of gestation. True positive and false negative patients were assumed to enter one of four health states: mild preeclampsia; severe preeclampsia; eclampsia; or death. Data pertaining to treatment practices, health care resource utilization, incidence, costs, and funding for detection and management of preeclampsia in the UK were obtained through interviews with clinicians, laboratory managers, and health care payers in the UK. Additional data were obtained from published literature and public databases.

RESULTS: Model results suggest that when used for screening, the novel test would reduce false negative diagnoses of preeclampsia by 67% and false positives by 71%. Costs per patient are estimated to be CHF 521 with the novel test and CHF 2726 with standard practice, saving an estimated CHF 493 per patient given the novel test. CONCLUSIONS: This test has the potential to improve detection and management of preeclampsia translating into substantial cost savings for UK health care payers.

EXAMINING THE COST IMPACTS OF RECONFIGURING TIA CARE IN SPAIN
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OBJECTIVES: Due to lack of awareness of Transient Ischaemic Attack (TIA) symptoms, many patients may not immediately seek medical help, creating delay in access to treatment. The UK EXPRESS study by Rothwell et al. (Lancet 2007;170:1432-42) demonstrated that a greater focus on rapid assessment and management of TIA could significantly reduce subsequent stroke rates. With nearly 35,000 cerebrovascular events per year in Spain last year, we wanted to examine how a shift in the care pathways towards that outlined in the EXPRESS study could affect stroke rates, and explore the financial implications of such a shift in care pathway. METHODS: We developed an economic model to estimate the costs and savings associated with establishing a rapid assessment and treatment clinic for patients with suspected TIA in Spain, in line with phase 2 of the EXPRESS study. We used a population of 1,000,000 people with an assumed annual incidence of TIA of 0.021%. Current management was based on ESO guidelines and common clinical practice. We included direct costs associated with care (medications, diagnostics and staff—where data were unavailable, converted UK costs were used), and modeled the impact of changing management over a three-year time horizon. RESULTS: For an assumed population of 1,000,000, changing the care pathway care to ensure rapid assessment and treatment for TIA patients would result in 66 future stroke events avoided over 3 years. As a result, the costs associated with changing the pathway of care for TIA would be partially offset by savings in acute costs associated with stroke. CONCLUSIONS: Our model suggests that implementing a revised TIA care pathway in Spain would reduce the number of TIA-related recurrent strokes, leading to reduced costs associated with acute stroke management. This would partially offset the cost of establishing rapid assessment and treatment clinics for patients experiencing TIA.

PCV54
BUDGET IMPACT ANALYSIS OF DIAGNOSTIC OF UNEXPLAINED AND/or RECURRENT SYNCOPE WITH APPLICATION OF IMPLANTABLE LOOP DETECTORS
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OBJECTIVES: Syncope that remains unexplained after a conventional evaluation is a common and vexing medical problem. Implantable loop recorder (ILLR) is a new diagnostic method in diagnosis of recurrent syncope with unexplained etiology (NO). The aim of this analysis was to estimate the impact of ILLR reimbursement in NO diagnostics on budget of public payer’s in Poland. METHODS: The analysis was performed in 3-year time horizon from the public payer’s perspective. Information regarding target population and medical resources was extracted from literature and registry PL-US. Data in the registry PL-US were collected during 2006–2008 in 18 Polish centers. Cost data were obtained from the National Health Fund. In the analysis two scenarios were compared: actual current situation with ILLR reimbursement only in special cases and diagnostic (after ILLR measurements). In the prognostic study, two financing options of monitoring of patients after ILLR implantation were distinguished—AOS and KAOS. One-way sensitivity analysis were performed for the key input parameters. RESULTS: The number of target population for ILLR implantation in Poland is stable, approximately 2,370 patients. In actual scenario estimated public payer expenditure for NO diagnostics in year 2010–2014 is in average approximately 9.00 mPLN, where cost of IRR is 0.25 mPLN. Assuming reimbursement of IRR estimated public payer expenditure for NO diagnostics in option AOS is 9.77 mPLN in year 2010 and 16.76 mPLN in year 2014 for IRR cost is 1.13 mPLN and in option KAOS public payer expenditure is 9.86 mPLN in year 2010 and 18.49 mPLN in year 2014, where ILLR costs is 1.53 mPLN and 13.07 mPLN, respectively. CONCLUSIONS: Our findings suggest that decision concerning IRR reimbursement should not lead to increase total expenses on the NO diagnostics for public payer more than 0.95 mPLN in year 2010 and 10.00 mPLN in year 2014.